1.247 On-Premise Time Off. On-premise paid time off (i.e., break time, paid meal time, etc.) should be reported as productive time and wages.

1.248 Self-Insurance Costs. The allowable expense for self-insurance plans is the actual claims paid during the cost reporting period. At the facility's option, accrual of pending claims may be made to the extent that such claims are paid within 75 days of the close of the cost reporting period. Such accrued claims may not be expensed in the following year's cost report. If a facility's self-insurance fund is managed by an independent (non-related) trustee, the fee paid to the trustee may be included in allowable self-insurance costs. If actuarial determinations are performed by an independent (non-related, non-employee) actuary, the fee paid to the actuary may be included in allowable self-insurance costs. Allowable self-insurance costs may also include the premium costs of re-insurance ("stop-loss") policies purchased from an unrelated company and any costs to administer the self insurance plan. Allowable costs shall then be reduced for investment income. In order for investment income to remain in the self insurance allowable cost determination, it must be separately identified and accounted for as related to the self insurance plan. If not separately identified, investment income will be treated according to Section 1.270 and/or Section 3.526. Any proceeds from these policies will be offset against the claims paid during the cost reporting period of receipt.

For purposes of implementing this section and payment plan, the terms self-insurance and self-funded are synonymous. Self-insurance is a means where a provider, either directly or indirectly or through a separate entity, trust or fund, undertakes the ultimate risk by assuming the actual liability for insurance costs as defined in this section. The creation of a separate entity, trust or fund for insurance purposes does not eliminate the provider's ultimate insurance risk or liability. Payment of insurance premiums to an insurance company, in the business of offering insurance to the general public, where such premiums are the final liability of the provider regardless of the actual cost incurred by the insurance company does not constitute self-insurance.

1.249 Provider Assessments or Provider Specific Taxes. Reimbursable expenses under these Methods will not include any cost attributable to taxes or assessments on occupied beds imposed by this State solely with respect to nursing homes or ICF-MRs.

1.250 Costs from Related Parties and Related Organizations.

1.251 Allowable Related Party Costs. A nursing home may incur expenses for services, facilities and supplies furnished by organizations related to the nursing home by common ownership or control. In lieu of such expenses incurred by the nursing home, allowable expenses for payment may include the expenses incurred by the related organization for the furnished items. Allowable expenses must not exceed the lesser of:

a. The expense incurred by the related organization for the services, facilities or supplies which the related party furnished to the nursing home, or

b. The price of comparable services, facilities or supplies that could be purchased elsewhere.

The purpose of this principle is to avoid the payment of a profit factor to the nursing home through the related organization, and also to avoid payment of artificially inflated expenses which may be generated from less than "arm's length" bargaining.

1.252 Definitions for Related Parties.

A "related party" or "related organization" is an individual or organization related to a nursing home by either common ownership or control.

"Related to the nursing home" means that the nursing home, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities or supplies.

"Common ownership" exists when an individual or individuals possess significant ownership or equity in the nursing home and in the institution or organization serving the nursing home.

"Control" exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

"Immediate family relationships" include husband/wife, natural parent, child, sibling, adoptive child and adoptive parent, step-parent, step-child, step-sibling, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent and grandchild.

1.253 Determination of Relatedness. In determining whether a nursing home is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. The existence of an immediate family relationship will create a rebuttable presumption of relatedness.

a. "Related by Common Ownership." A determination as to whether an individual(s) or organization possesses significant ownership or equity in the nursing home organization and the supplying organization, so as to consider the organizations related by common ownership, should be made on the basis of the facts and circumstances in each case. This principle applies whether the nursing home or the supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of a nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization (for example, a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).

b. "Related by Control." The term "control" includes any kind of control which is exercisable, regardless of legal enforceability. It is the reality of the control which is decisive, not its form or mode of its exercise. The facts and circumstances in each case must be examined to ascertain whether legal or effective control does exist. Since a determination reached in a specific case represents a conclusion based on the entire body of facts and circumstances involved, such determination should not be used as a precedent in other cases unless the facts and circumstances are substantially the same.

c. "Exception." An exception is provided to the general rule applicable to related organizations. The exception is intended to cover situations where large quantities of goods and services are furnished to the general public and only incidentally are furnished to a nursing home by a related organization. The exception applies if the provider demonstrates to the satisfaction of the Department that the following criteria are met:

1. The supplying organization is a bona fide separate organization.

2. A substantial part of the supplying organization's business activity as engaged with the nursing home is transacted with other organizations not related to the nursing home and the supplier by common ownership or control AND there is an open, competitive market for the type of services, supplies or facilities furnished by the organization.

3. The services, supplies or facilities are those which commonly are obtained by nursing homes from other organizations and are not a basic element of patient care ordinarily furnished directly to patients in nursing home operations.

4. The charge to the nursing home is in line with the charge for such services, supplies or facilities in the open, competitive market, and no more than the charge made by the organization, under comparable circumstances, to other customers for such services, supplies or facilities.

If all the above conditions are met, the charge by the related supplier to the nursing home for such services, supplies or facilities shall be an allowed expense for payment.

1.254 Documentation. The nursing home must make available to the Department adequate documentation to support the costs incurred by the related organization, including access to the related organization's books and records concerning supplies and services furnished to the nursing home. Such documentation must include an identification of the organization's total costs, and the basis of allocation of direct and indirect costs to the nursing home and to other entities served.

1.255 Medicare Influence. Generally, the Department will refer to the Medicare Program's guidelines and interpretations when examining payment issues arising out of costs to related organizations.

1.256 Related Party Compensation. Any form of compensation to owners or related parties which is included in the payment rate must be reasonable and necessary. "Reasonable" means that the compensation should not exceed what would be paid by other nursing homes or the home in question for similar services. "Necessary" means that the services are required and commonly performed in other nursing homes and that, if the services were not performed by the owner or related individual, another person would have to be employed or contracted to perform them. Workers, who are members of the religious order (or society) which owns the nursing home, are to be treated as related parties under this section.

1.260 Employee Compensation. Any form of compensation which is included in the payment rate must be reasonable and necessary. "Reasonable" means that the compensation should not exceed what would be paid by other nursing homes or the home in question for similar services. "Necessary" means that the services are required and commonly performed in other nursing homes.

1.265 Out-of-State Travel. Out-of-state travel and related travel expenses shall not be allowed, except for travel expenses to and from the nursing home's home office. This provision shall not apply to travel within 100 miles of the Wisconsin border or to home office personnel with one or more nursing homes located outside the State of Wisconsin. Travel expenses shall include but not be limited to meals, lodging, transportation, and all training, seminar and convention fees and expenses associated with the out-of-state trip.

1.266 Definition of Investment Income. Investment income consists of the aggregate net amount from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss is not allowable.

1.270 Interest Expense on Working Capital Debt. Working capital loans are debts entered into by a provider to finance current operations until current cash flow allows payment of the debt. Such debts may carryover from a recent fiscal year to the current fiscal year. Only interest expense on operating working capital loans which are related to patient care shall be allowed to be included in the calculation of the administration and general allowance. The Department shall determine allowable expense and shall include the following adjustments.

1. Revenues from any invested funds shall be offset against working capital interest expense; such revenues remaining after the offset may be offset under Department policy in determining the property allowance per Section 3.500.

   a. Investment income earned by any home office, other corporate entity or organization, foundation or related party that has a purpose of furthering the goals and objectives of the nursing home or its related organizations, shall be offset against the nursing home's allowable interest expense. Long term interest expense and working capital interest expense shall be offset by investment income from all sources (including home office, other corporate entities or organizations, foundations and related parties). Offsets from these entities shall be applied after offsets to interest expense at the home office, other corporate entities or organizations, foundations and related parties are made. Offsets to the nursing home shall be allocated based on the home office or foundation acceptable allocation basis. The investment income offset shall first be applied to working capital interest expense and then to long term interest expense.

   b. Investment income generated to meet specific financial reserve requirements of the Office of Commissioner of Insurance or other regulatory agencies will be exempt from the income offset requirement.

2. Interest expense on borrowed funds which are not used for operating the nursing home shall not be allowable.

3. An amount will be disallowed from working capital interest expense by applying an 8.3% per annum interest factor to the following amounts from the base cost reporting period. This standard disallowance shall only be applied to interest expense which exceeds $.10 per adjusted patient day (after applying 1 and 2 above).

   a. Disallowed compensation;

   b. Disallowed expenses;

   c. Stockholder dividends and owners equity distributions during the base cost reporting period;

4. This adjustment (4) will only be applied to any interest expense which exceeds $.20 per adjusted patient day after applying adjustment 3 above. An amount will be disallowed from interest expense by applying 8.3% to the following amounts from the cost reporting periods which were used in calculating the June 30th payment rate for the three years prior to the current payment rate year.

   a. Disallowed compensation;

   b. Disallowed expenses;

   c. Stockholder dividends and equity distributions during the cost reporting periods.

5. Interest on debts to acquire plant assets, which is not reimbursed under the property allowance in Section 3.500, shall not be allowed as interest in the administrative component.

1.281 Therapy and Beauty and Barber Shop Spaces. Support service, fuel and utility, property tax, and property expenses which are indirectly allocated to therapy services and beauty and barber services, on the basis of the building area which those services use, shall be generally allowed in the calculation of the payment rate. If gross therapy revenues (physical, occupational, and speech) are less than $100,000 for the applicable cost reporting period, then space allocations will not be made. If gross therapy revenues (physical therapy, occupational therapy, and speech therapy) generated in nursing home therapy space attributable to non-nursing home residents equal 2% or more of total gross therapy revenues and/or if the nursing facility (or a related party as defined in Section 1.252) bills Medicare Part B for therapy generated in the nursing facility therapy space and the Medicare Part B revenues equal 10% or more of the total therapy revenues, then space allocations shall be made on a square footage basis. If the nursing home is subject to an allocation under the Medicare Part B criterion, then the non-nursing home resident allocation will be made if there are any non-nursing home resident therapy revenues. These qualifying criteria are based on the facility's cost reporting period for the payment rates.

1.282 Transportation. Revenues from transportation services shall be offset against transportation or administrative cost center expenses. In lieu of a revenue offset, expenses appropriately allocated by the nursing home to the revenue-generating transportation services may be offset against the cost center expenses.

1.290 Institutions for Mental Disease and Mentally Ill Nursing Home Residents. Sections 1.291 through 1.294 describe limitations on payments to institutions for mental disease and nursing homes for the care of mentally ill residents, as required by 1987 Act 399.

1.304 Definition of Significant Changes in Licensed Bed Capacity. Unless otherwise stated in this Methods, a significant increase or decrease in licensed bed capacity is defined as the lesser of: (1) a change that is greater than or equal to 25.0% of the previously unrestricted use licensed beds or (2) 50 beds.

1.305 New Facilities. A new facility is defined as a nursing home newly beginning operation and not previously licensed as a nursing home. A change in ownership does not constitute a new facility. An existing operation, which becomes certified for the Medicaid Program, shall not be considered a new facility.

1.306 Replacement Beds and Facilities. A replacement is defined as the licensure and certification by a Medicaid provider of beds to take the place of beds closed or de-licensed by the same or a related provider. Total replacement means all beds under a provider's certification were replaced. The resulting licensed bed capacity of the provider may be considered a significant increase or decrease in licensed beds if the criteria of Section 1.304 are met.

1.307 Adjusted Patient Days. The term "adjusted patient days" means patient days, including therapeutic and hospitalization bed hold days, as reduced to recognize the 15% discount on the payment rate for bed hold days and other adjustments determined by the Department. For example, 1000 patient days, including 100 bed hold days, would be reduced by 15 days (i.e. 15% x 100) to 985 adjusted patient days.

1.308 Fringe Benefits. The term "fringe benefits" refers to general fringe benefits for staff as defined in detail by the Department in the Title XIX nursing home cost report form. Significant, unique benefits, as defined in the cost report form, are to be included as a salary or wage expense under this Methods and not as a fringe benefit expense. For facilities with special salary and wage payments to employees, such as bonuses, the Department shall classify such payments as salaries instead of fringe benefits.

1.309 Average Licensed Beds. The term "average licensed beds" means the average of the number of licensed beds of the facility at the beginning of each month of the period for which the average is being determined. An average for a one-month period shall be the average of the daily number of licensed beds.

1.310 Significant Licensed Bed Days. A significant number of licensed bed days is the lesser of 4500 licensed bed days or 25.0% of the annualized bed days of the provider.

1.311 Distinct Part ICF-MR. A distinct part ICF-MR is a specific segment of a licensed NF facility which has been certified by the Department as a distinct part intermediate care facility for the mentally retarded.

1.312 Institution for Mental Disease (IMD). An institution for mental disease (IMD) is an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services as determined by the Department or the federal Health Care Financing Administration. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental disease.

1.313 Restricted Use Beds. Restricted use beds are those beds that have been acquired by sale or transfer from a separate licensee and which cannot be occupied by patients pending Chapter 150 approval of construction of a facility that can accommodate the beds. Restricted use beds are not to be used for determining bed hold occupancy requirements. Restricted use beds with a restricted use license issued prior to July 1, 1995, will not be included in the average licensed beds under Section 1.309. Restricted use beds with a restricted use license issued after June 30, 1995, will be included in the average licensed beds under Section 1.309.

1.314 Payment Rate Year. The payment rate year is the twelve month period from July 1, 1999 through June 30, 2000.

1.315 Patient Day. A patient day is one in which a patient, regardless of pay source, resides in a nursing facility for any part of a calendar day. This includes the day of admission but not the day of discharge. If the day of admission and discharge are the same it will be considered one patient day. Bed hold days reimbursed by the fiscal intermediary or patient are considered a patient day (Medicaid bed hold days must meet the billable criteria identified in Section 1.500.) A patient day can not be counted as both a patient day and a bed hold day.

1.316 Beds for Rate Setting. The beds for rate setting will be calculated as described in Section 3.040.

-- All hospital leaves of absence up through 15 days per hospitalization
-- All leaves for therapeutic visits
-- All leaves for therapeutic rehabilitative programs meeting the criteria under HFS 107.09(3)(j), Wis. Adm. Code.

1.600 RESOURCE ALLOCATION PROGRAM RATES AS A MAXIMUM

The per patient day property allowance stated in an application to the state's resource allocation program under Chapter 150, Wis. Stats., is the maximum allowable payment that may be granted by the Department for applications not involving the addition of beds for the first full year following completion of the project. In an application for approval of additional beds, the per patient day rate(s) stated in an application to the State's resource allocation program under Chapter 150, Wis. Stats., is the maximum allowable reimbursement that may be granted by the Department for the twelve months following licensure of the additional beds. If the Methods generates per patient day rates or per patient day property allowance that are less than those stated in the application, the Department shall use the lower rate(s) or allowance.

This section does not apply to ICF-MR facilities certified after June 30, 1988.

Resource Allocation Program maximums shall be applied for the first full year following completion of a project or the time period specified in the RAP approval.

1.700 CHAPTER 227 ADMINISTRATIVE HEARINGS

A facility may contest a final rate-setting action of the Department by writing to the Department of Administration's Division of Hearings and Appeals at P.O. Box 7875, Madison, WI 53707-7875. The rate approval letter issued to the facility by the Department is the formal written Notice of Action required by the state administrative code (Reference: HFS 106.12, Wis. Adm. Code). The request for hearing must be served within 15 days of receipt of a Notice of Action. It must contain a brief and plain statement identifying every matter or issue contested.

1.800 ADMINISTRATIVE REVIEWS

A facility may request an administrative review of the Department's cost finding decisions prior to the issuance of a rate approval letter. The request must be filed within 30 days of the facility's receipt of the notification of Medicaid nursing home rates and shall be subject to any other procedures or criteria developed by the Department. A facility's failure to file a timely request for an administrative review shall have no bearing on the facility's right to file a request for administrative hearing under Section 1.700 or an appeal to the Nursing Home Appeals Board under Section 1.400 upon issuance of the rate approval letter.

1.900 MEDICARE BILLING

Facilities must bill Medicare for covered services and supplies. Facilities that bill Medicare for applicable Part B services must be dually-certified facilities, and must bill Medicare for Medicare-covered services or supplies prior to billing Medicaid. Providers are expected to bill the Medicare Part B program for any services or supplies for residents covered by that program. Should a provider not exhaust Medicare Part B sources of revenue, then the Department may offset that amount or an estimate of that amount which could be billed to Medicare Part B. This policy applies to facilities which do not bill Medicare at all or do not exhaust Medicare to the extent available for applicable Medicare third-party liability.

SECTION 2.000 PAYMENT RATE ALLOWANCES DESCRIBED

This Methods provides for payments which are divided into seven major cost centers: Direct Care; Support Services; Administrative and General; Fuel and Utilities; Property Tax; Property and Over-the-Counter Drugs. Section 2.000 describes the types of services and costs generally covered by each cost center. The calculation of the payment allowances is described in Section 3.000.

2.100 DIRECT CARE ALLOWANCE

The direct care allowance shall reimburse for allowable facility expenses related to the provision of the following purchased and/or provided services and supplies, (which include, but are not limited to, staff wages, fringe benefits, and purchased services costs) up to maximums discussed in Section 3.100.

2.110 Professional Nursing Services. Professional nursing services shall include all registered nurses, nurse practitioners and licensed practical nurses.

2.120 Supporting Care Services. Supporting care services shall include technical, non-professional resident living staff, volunteer coordinators, nurses aides and ward clerks, activity and recreation staff, and therapy aides and assistants.

2.130 Professional (Non-Medical/Clinical Care) Services. Professional care services shall include: teachers and vocational counselors for residents aged 22 and over, social services, educational and vocational expenses that are part of an active treatment plan in facilities licensed as ICF-MRs, chaplain and religious services, and the non-billable services of pharmacy, x-ray, laboratory, dentists, physicians, physician assistants, licensed registered therapists, chiropractors, psychiatrists, and psychologists. Non-billable services generally include those types of services which are provided to the facility as a whole instead of to an individual resident and/or which are not billable separately to the Medicaid Program per HFS 107, Wis. Adm. Code.

The cost of non-covered services identified in HFS 107, Wis. Adm. Code or Department policies shall not be reimbursed.

Expenses for the time to perform overhead activities related to billable therapy evaluations, procedures and modalities are not to be included in the rate calculation and are not to be considered in the cost report category of "non-billable expenses." Activities such as end-of-the-day clean-up time, transportation time, consultation and required paper reports are considered to be overhead activities.

Any nursing personnel, quality assurance personnel and/or therapy consultants who do not provide direct, hands on patient care shall be considered administrative and general expenses.

2.135 Inservice Training. The expense of providing inservice training for any of the above personnel shall be included in the calculation of the direct care allowance. Expenses relating to nurse aide training and competency evaluation programs (NAT/CEP) mandated by OBRA shall not be included in the daily rate; separate reimbursement is provided for the direct expenses incurred by a nursing facility for NAT/CEP that is required before an aide can be entered on the Nurse Aide Registry.

2.140 Personal Comfort, Medical Supplies. Personal comfort, medical supplies and other similar supplies, along with special care supplies are included in the direct care allowance. Section 5.100 of this Methods contains further guidelines on, and a list of, the personal comfort and medicine chest-type supplies which are intended to be included under this provision.

2.150 Incontinent Supplies. Incontinent supplies shall include the cost of underpads, blue pads, disposable diapers, reusable diapers, the purchased service costs of a diaper/underpad service, catheter sets and supplies, and bladder irrigation sets and supplies. Section 5.100 of this Methods contains further guidelines on, and a list of, the incontinent-type supplies which are intended to be included under this provision.

2.200 SUPPORT SERVICES ALLOWANCES

The support services allowance recognizes the allowable expenses to provide dietary and environmental services up to amounts payable under Section 3.200. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services.

2.210 Dietary Service Expenses. Dietary service expenses are those expenses directly related to the provision of meals to residents of the facility, including dietary supplements and dietician consultants.

2.220 Environmental Service Expenses. Environmental service expenses are generally those expenses related to the provision of maintenance, housekeeping, laundry and security services. Also included are expenses related to residents' personal laundry services, excluding personal dry cleaning services.

2.250 ADMINISTRATIVE AND GENERAL SERVICES ALLOWANCE

The administrative and general service allowance recognizes the allowable expenses for administrative, central office services and management services contract fees up to amounts payable under Section 3.250. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services.

2.251 Administrative Service Expenses. Administrative service expenses include those expenses related to the operation's overall management and administration, and other allowable expenses which cannot be appropriately recognized/reimbursed in other payment allowances or service areas. Expenses for the provision of general administrative, clerical, financial, accounting, purchasing, data processing, medical records and similar services are usually considered administrative expenses. Also included are allowable expenses for non-medical transportation, telephone, office supplies, training fees, license fees, insurance (except property, mortgage and general employee benefit insurance), working capital interest expense, amortized financing acquisition costs and other similar expenses. A nursing home may also include the allowable ownership and/or rental expenses of telephone equipment, and computer and electronic data processing equipment. (Inservice training, see 2.135) (Legal expenses, see 1.245) (Interest expense, see 1.270)

2.252 Central Office Costs. Administrative expenses allocated to the nursing home from centralized administrative units of nursing home chain organization or governmental agencies shall be recognized among administrative service expenses, including the centralized unit's allocated overhead expenses such as maintenance, utilities and depreciation. Salaries and fringe benefits for any nursing personnel, quality assurance personnel, and therapy consultants who report to a centralized administrative unit, but do not provide direct hands-on patient care shall be included as central office costs. Expenses may be adjusted by the Department for unreasonable or unnecessary expenses or duplicative services.

A facility that claims both central office expense and in-house administrative and general expense will be subject to the following standards for reasonable and necessary salary and fringe benefit expense in this cost center:

If total in-house salary and fringe benefits are greater than or equal to the Central Office Cost allowance which is $6.36 per patient day, no central service salary or fringe benefits is allowed.

If total in-house salary and fringe benefits is less than the per patient day Central Office Cost allowance, then central service salary and fringe benefit expense is allowed to bring the total in-house and central service salary and fringe benefits to a maximum per patient day Central Office Cost allowance of $6.36.

2.253 Management Service Contract Fees. Management service contract fees shall be recognized among administrative service expenses, but may be adjusted by the Department for unreasonable or unnecessary levels of service, compensation, or duplicative services. Fees resulting from a percentage of cost or revenue arrangement will be disallowed by the Department, in whole or in part, according to the policy established by the Department.

2.254 Nursing Home Valuations. The cost of Department-required nursing home property valuations conducted by a Department-approved contractor shall be recognized among administrative service expenses.

2.255 Exceptional Medicaid Utilization Adjustment. Nursing homes, other than those owned and operated by a governmental entity, with exceptional Medicaid utilization may receive an adjustment based on their Medicaid utilization compared to the average for comparable nursing homes. Nursing homes with 70.0% or greater Medicaid utilization shall be considered to have exceptional utilization. Ownership status is determined as of the last day of the cost report. If a governmental facility changes ownership status, it will not be eligible for this adjustment until such time that the change in ownership status has been reflected on the cost report used to set the rate for the applicable rate year.

2.300 FUEL AND OTHER UTILITY EXPENSE ALLOWANCE

The fuel and other utility expense allowance shall consist of allowable facility expenses related to the provision of electricity, water and sewer services, and heating fuel including fuel oil, natural gas, LP gas, coal and other heating fuels.

2.400 PROPERTY TAX ALLOWANCE

2.410 Tax-Paying Facilities. The property tax allowance shall be a per patient per day amount for allowable property tax expense. Allowable property tax expense shall exclude any state property tax credit and any special assessments for capital improvements, such as sewers, water mains and pavements. Whenever exemptions to property tax are legally available, the provider shall be expected to pursue such exemptions. If the provider does not pursue available exemptions, the expenses incurred for property tax shall not be allowed.

2.420 Tax-Exempt Facilities. The property tax allowance for tax-exempt facilities may include a per patient per day amount for the cost of needed municipal services. Includable municipal services will be limited to those services which are financed through the municipality's property tax and which are provided by the municipality to property taxpayers without levying a special fee for the service. A tax-exempt facility may be paying a municipal service fee to the municipality for the services or may provide the service and incur the cost in their own operation.

2.500 PROPERTY PAYMENT ALLOWANCE

The property payment allowance will be a per patient day amount based upon the value of a facility's buildings as estimated by a commercial estimator, target amounts based on service factors established by the Department, and the nursing home's allowable property-related expenses. The estimation will conform with guidelines determined by the Department. This allowance covers, in whole or in part, the nursing home's expenses related to ownership and/or rental of the land, land improvements, buildings, fixed and movable equipment, and other physical assets.

2.600 OVER-THE-COUNTER DRUG ALLOWANCE. The Department will reimburse for nonprescription charges approved by the Department through an over-the-counter drug allowance which recognizes the allowable expenses to provide certain over-the-counter drugs, ordered by a physician, to Wisconsin Medicaid nursing home residents up to amounts payable under Section 3.600. The allowable expenses may include the average wholesale price of the drugs and any pharmacy dispensing costs. Pharmacy dispensing costs shall not exceed 50% of the pharmacy's average wholesale price of the drug.

SECTION 3.000 CALCULATION OF PAYMENT ALLOWANCES

3.001 Introduction. The payment allowance calculations are described in this section. For the payment system, the calculations of the allowances are on a per patient day basis. The patient days may be adjusted for minimum occupancy.

3.010 Patient Days. The patient days used to calculate allowances per patient day shall be the greater of: 1) the adjusted patient days (Section 3.020) based on the base cost reporting period (Section 1.302); or 2) patient days at minimum occupancy (Section 3.030).

3.020 Adjusted Patient Days. The term "adjusted patient days" means patient days, including therapeutic and hospitalization bed hold days, as reduced to recognize the 15% reduction on the payment rate for bed hold days and other adjustments determined by the Department. For example, 1000 patient days, including 100 bed hold days, would be reduced by 15 days (i.e. 15% x 100) to 985 adjusted patient days.

3.030 Patient Days at Minimum Occupancy. The minimum occupancy standard is 91%. The patient days at minimum occupancy are determined by multiplying the beds for rate setting (Section 3.040) by the days in the cost reporting period by the minimum occupancy standard.

3.040 Beds for Rate Setting. The beds for rate setting will be the licensed beds on July 1, 1999. These bed amounts will be changed by the following as applicable:

- adjustments (Section 3.050) and/or
- beds in the bed bank (Section 3.060)

3.050 Adjustments. 1) If a free-standing ICF-MR facility has decreased its use of unrestricted licensed beds by the lesser of 10 beds or 10%, the facility may request that the reduced number of beds to be used in calculating the patient days at minimum occupancy (Section 3.030). Any resulting rate change is to be effective the first of the month following the decrease in licensed beds.

2) Restricted use beds with a restricted use license issued before July 1, 1995 will be excluded from the beds for rate setting.

3) Beds associated with RAP projects will be excluded from Beds for Rate Setting if the project(s) is completed by July 1, 2000.

3.060 Bed Bank. The Department shall exclude banked nursing home beds from the beds for rate setting (Section 3.040). The number of beds a facility has in the bank on July 16, 1999 will be the adjustment for Section 3.040.

For bed bank requests submitted after July 16, 1999, the bed adjustment will be effective July 1, 2000, subject to the Methods then in effect.

If a bed license is split, causing a transfer of beds, between more than one facility and there are banked beds on the license, a new rate will be calculated for each facility, effective July 1, 2000, subject to the Methods then in effect, unless Sections 4.400 or 4.500 apply.

3.061 Bed Bank Reductions and Resumption. The Department shall allow the nursing home to exercise the right to resume use of banked beds, unless PERMANENTLY reduced by s. 49.45(6m), with licensure resumption contingent upon receipt of a 18 month prior notice to the Department. Permanent reduction shall occur if any banked beds remain delicensed under this paragraph at the rate of 10% of all remaining delicensed banked beds or 25% of one bed, whichever is greater.

3.062 Bed Bank Restrictions.

a. If any of the provisions of Section 4.500 are being applied during the payment rate year to a facility that phases down or closes, then that facility does not qualify for banking of beds.

b. The total beds for rate setting and banked beds cannot exceed the total licensed beds.

c. Banked beds cannot be occupied by any resident. If such use is discovered and such use would raise the number of occupied beds above the number of licensed beds minus banked beds, all beds banked by the facility will be expunged from the bank and the banked beds will be delicensed permanently.

   If such use is discovered but does not exceed the number of licensed beds minus banked beds, the facility has 30 days to correct the occupancy or the beds involved will be expunged from the bed bank and will be delicensed permanently.

3.126 Facility Direct Care Maximum

The facility's Case Mix Index is the average of the case mix values in Section 5.420 weighted by the adjusted patient days for each level.. Thus,

Case Mix Index = Σ(Adjusted Patient Days by Level of Care * Case Mix Weights) / Total Adjusted Patient Days

The facility's Direct Care Maximum is the product of its Case Mix Index times the Statewide Direct Care Maximum in Section 5.430 times the "New" Labor Factor in Section 5.410. Hence,

Direct Care Maximum = Case Mix Index * Statewide Direct Care Maximum * Labor Factor

3.126(a) Adjustment to Maximum. The maximum used will be increased by twenty percent (20%) for facilities that have beds for rate setting (Section 3.040) of fifty beds or less and are certified only as a nursing facility. Facilities that are certified as ICF-MR facilities either in whole or in part are not eligible to have its maximum adjusted under this section.

3.127 Direct Care Base Allowance

The facility's Direct Care Base Allowance is the lesser of the facility's actual allowable expense per patient day times the minimum occupancy factor in Section 3.127(a) or the maximum in Section 3.126 times the minimum occupancy factor in Section 3.127(a).

3.127(a) Minimum Occupancy Factor for Direct Care. If a facility's adjusted patient days under Section 3.115 are less than the minimum occupancy standard under Section 3.010, the minimum occupancy factor will be the ratio of the actual occupancy to the minimum occupancy.

3.128 Direct Care Reimbursement Period Allowance

The facility's Average Reimbursement Period Allowance will be its Base Allowance plus an Inflation Increment. The inflation increment is the facility's Case Mix Index times the Statewide Inflation Increment in Section 5.440. Thus,

Average Reimbursement Period Allowance = Base Allowance + Inflation Increment

Where

Inflation Increment = Case Mix Index * Statewide Inflation Increment

The Reimbursement Period Allowance shall be allocated proportionately by Level of Care. This allocation is done by dividing the Reimbursement Period Allowance by the facility's Case Mix Index and multiplying the result by the Case Mix Weights in Section 5.420.

3.129 Alternate Direct Care Reimbursement Period Allowance

The Alternate Direct Care Allowance will be calculated as set forth in Sections 3.126, 3.127 and 3.128 except that the "Old" Labor Factor in Section 5.410 will be used in calculating the facility's Direct Care Maximum and no Inflation Increment will be added to the Base Allowance. The facility will receive the greater of the Direct Care Reimbursement Period Allowance under Section 3.128 or the Alternate Direct Care Reimbursement Period Allowance.

3.200 SUPPORT SERVICES ALLOWANCE

3.220 Method of Calculation. Allowable expenses associated with a facility's provision of dietary and environmental services shall be combined, and payment determined, according to the following modified cost formula:

P = Dietary and Environmental services payment allowance

E = Facility's actual allowable expenses for dietary and environmental services (per patient day) adjusted by a composite inflation/deflation factor applied to the common period. The inflation factors are listed in Section 5.320.

T1 = Target 1 as described in Section 5.510

T2 = Target 2 as described in Section 5.510